



**STATE OF IOWA DNR LAW ENFORCEMENT**  
DEPARTMENT OF NATURAL RESOURCES  
WALLACE STATE OFFICE BUILDING  
502 EAST 9<sup>TH</sup> STREET  
DES MOINES, IOWA 50319-0034  
[www.iowadnr.gov](http://www.iowadnr.gov)

**For Office Use Only**

USCG Assigned Number:

DNR Case Number:

Form Revised: 04/08

**VESSEL OCCURRENCE OPERATOR'S REPORT FORM**

The operator of a vessel involved in an occurrence is required to file a report in writing whenever an occurrence results in loss of life; loss of consciousness, medical treatment or disability in excess of 24 hours or property damage in excess of \$2000. The report must be submitted within 48 hours in death, disappearance, or personal injuries requiring medical treatment by a licensed health care provider, and within five days in all other cases. All reports shall be submitted to the Iowa DNR Law Enforcement Bureau, Wallace State Office Building, 502 E 9<sup>th</sup> St, Des Moines, IA 50319-0034, and shall include a full description of the collision, occurrence or other casualty. If you have any questions, call the DNR Des Moines Office – (515) 281-5918.

**OCCURRENCE DATA**

Date (month, day, year) of occurrence		Actual local time <input type="checkbox"/> AM <input type="checkbox"/> PM		Number of boats	Number of injuries/fatalities ____ Injuries ____ Fatalities
Nearest city or town	County	State	Body of water		Location (give precisely)
<b>Water condition</b> <input type="checkbox"/> Calm <input type="checkbox"/> Strong Current <input type="checkbox"/> Rough <input type="checkbox"/> Very Rough		<b>Wind (MPH)</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate (7-14) <input type="checkbox"/> Storm (over 25) <input type="checkbox"/> Light (0-6) <input type="checkbox"/> Strong (15-25)		<b>Weather</b> <input type="checkbox"/> Clear <input type="checkbox"/> Fog <input type="checkbox"/> Snow <input type="checkbox"/> Cloudy <input type="checkbox"/> Rain <input type="checkbox"/> Hazy	
<b>Visibility</b> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Night		<b>Personal Flotation Devices (PFD's)</b> <input type="checkbox"/> Vessel equipped with PFD's <input type="checkbox"/> Used by survivors <input type="checkbox"/> Accessible If used list type:		<b>Fire Extinguishers</b> <input type="checkbox"/> On board If used list type: <input type="checkbox"/> Used	
<b>Operation at time of occurrence</b> <input type="checkbox"/> Commercial activity <input type="checkbox"/> Maneuvering <input type="checkbox"/> Leaving dock <input type="checkbox"/> Racing <input type="checkbox"/> Being towed <input type="checkbox"/> At anchor <input type="checkbox"/> Fueling <input type="checkbox"/> Hunting <input type="checkbox"/> Other (specify):		<input type="checkbox"/> Cruising <input type="checkbox"/> Approaching dock <input type="checkbox"/> Water skiing <input type="checkbox"/> Towing <input type="checkbox"/> Drifting <input type="checkbox"/> Tied to dock <input type="checkbox"/> Fishing <input type="checkbox"/> Skin diving/swimming		<b>Type of occurrence</b> <input type="checkbox"/> Grounding <input type="checkbox"/> Flooding <input type="checkbox"/> Fire or explosion (fuel) <input type="checkbox"/> Collision with vessel <input type="checkbox"/> Collision with fixed object <input type="checkbox"/> Falls in boat <input type="checkbox"/> Other (specify): <input type="checkbox"/> Capsizing <input type="checkbox"/> Sinking <input type="checkbox"/> Fire or explosion (other) <input type="checkbox"/> Hit by boat or propeller <input type="checkbox"/> Falls overboard <input type="checkbox"/> Fallen skier/tubing	

**OPERATOR VESSEL 1 (THIS VESSEL)**

Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of birth	Telephone number ( )
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Address (number and street, city, state, and zip code)

<b>Operator's experience (this vessel)</b> <input type="checkbox"/> Under 20 hours <input type="checkbox"/> 20 – 100 hours <input type="checkbox"/> 100 to 500 hours <input type="checkbox"/> Over 500 hours		<b>Operator's formal instruction in boating safety</b> <input type="checkbox"/> None <input type="checkbox"/> USCG Auxiliary <input type="checkbox"/> State <input type="checkbox"/> U.S. Power Squadron <input type="checkbox"/> Other (indicate):
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**VESSEL 2 (IF MORE THAN TWO VESSELS, ATTACH ADDITIONAL FORM(S))**

Name of operator	Telephone number ( )	Name of owner	Telephone number ( )
Address (number and street, city, state, and zip code)		Address (number and street, city, state, and zip code)	
Vessel registration number:	Registration expiration date:	Make:	Model:

VESSEL 1 (THIS VESSEL)						
Name of owner			Rented vessel		Insurance company:	
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Address of owner (number and street, city, state, and zip code)					Owner's telephone number	
					(      )	
Registration number		Registration expiration date		Registration onboard		Location of vessel after occurrence:
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Capacity plate and engine information				Vessel data		
_____ LBS.                      _____ Number of persons _____ H.P. rating                      _____ Number of engines _____ Actual H.P.      Engine make: _____				_____ Length                      _____ Width _____ Height of transom Hull Identification Number: _____		
<input type="checkbox"/> Outboard <input type="checkbox"/> Inboard – Gas <input type="checkbox"/> Inboard – Diesel <input type="checkbox"/> I/O <input type="checkbox"/> Jet						
Year	Vessel Make		Vessel Model		Vessel Color	Vessel Type
USCG documented (name and number)			Estimated damage \$		Other property damage \$	
DESCRIPTION OF OCCURRENCE						
<i>Explain how the occurrence happened, including the sequence of events and describe any damage if applicable. If a diagram can be provided please attach.</i>						
PEOPLE INVOLVED VESSEL 1 (THIS VESSEL) - IF MORE THAN THREE, ATTACH ADDITIONAL FORM(S)						
<input type="checkbox"/> Injured <input type="checkbox"/> Deceased <input type="checkbox"/> Occupant <input type="checkbox"/> Witness						
Name			Age	Date of birth		Telephone number
						(      )
Address (number and street, city, state, and zip code)				Name of injury/cause of death/location at time of occurrence		
<input type="checkbox"/> Injured <input type="checkbox"/> Deceased <input type="checkbox"/> Occupant <input type="checkbox"/> Witness						
Name			Age	Date of birth		Telephone number
						(      )
Address (number and street, city, state, and zip code)				Name of injury/cause of death/location at time of occurrence		
<input type="checkbox"/> Injured <input type="checkbox"/> Deceased <input type="checkbox"/> Occupant <input type="checkbox"/> Witness						
Name			Age	Date of birth		Telephone number
						(      )
Address (number and street, city, state, and zip code)				Name of injury/cause of death/location at time of occurrence		
Printed name of person submitting this report			Signature			Date submitted